Testimony by Marcia DuFore
On behalf of the North Central Regional Mental Health Board
Before the Public Health Committee
Regarding: HB 5271
February 24, 2016

Senator Gerratana, Representative Ritter and distinguished Senators and Representatives of the Public Health Committee,

My name is Marcia DuFore and I am a registered voter in the town of Suffield, Connecticut. I am testifying as Executive Director on behalf the North Central Regional Mental Health Board (NCRMHB) and as an active member of the Keep the Promise Coalition.

Thank you for the opportunity to offer comment regarding Raised Bill 5271: An Act Concerning Mental Health Training in State and Local Police Training Programs and the Availability of Providers of Mental Health Services on an On-Call Basis.

Our Board's responsibility, established by Connecticut statute 40 years ago, is to study the mental health needs of people in our region and assist the Department of Mental Health and Addiction Services (DMHAS) with setting priorities. Toward that end NCRMHB staff and volunteer members conduct evaluations of state funded community mental health services available in our region and make recommendations about ways to improve or expand services to address community needs.

We commend you for addressing the need for police training on topics of mental illness and developmental disabilities and for requiring some minimum standards for that training.

Last year NCRMHB completed an evaluation of the Region IV crisis response system (see executive summary attached) that included a review of access to services and supports for continuity of care post crisis. It is disheartening to see how often our system relies on emergency responders as the point of access for mental health care and how often the only course of action for emergency responders is to send the person to the hospital for psychiatric evaluation or admission. As an outcome of our review, NCRMHB made a series of recommendations to DMHAS about ways to enhance crisis response and the system of care post crisis. One of those recommendations, pertinent to Raised Bill 5271, was for additional training for emergency responders (police and EMTs). The Crisis Intervention Team training (CIT) (40 hours) offered by the CT Alliance to Benefit Law Enforcement and Mental Health First Aid Training for Public Safety Personnel (8 hours) are two such training programs we have found to be highly effective. CIT training is considered the gold standard in this realm and is highly sought after by a growing number of police departments and most police departments in our region.

As reflected in our evaluation report, NCRMHB finds it to be of critical importance for communities to have more tools in their tool kit for crisis response than that of well-trained police personnel. Our number one recommendation was to increase the collaboration and communication between all crisis care professionals (mobile crisis, emergency and inpatient psychiatric settings, town social services, police, and shelter programs). Given that DMHAS already has mobile crisis teams in place using clinicians with specialized training in addressing crisis situations on the street, in peoples' homes, and in the community, it appears to us duplicative and less than effective to require municipalities to hire, train, and supervise staff to carry out this function. Currently mobile crisis teams are understaffed and underfunded, therefore they are not available 24/7 and are not able to arrive on scene as quickly as the police. It would make more sense and be less expensive for the state to provide funding to enhance these teams so they could expand their ability to do what they do best. We have observed excellent working relationships between mobile crisis staff, police, and other community services in several of our Region IV communities. Such relationships lead to better connections to care and better short and long term outcomes for people. We hope you will consider these remarks in your deliberations.

Thank you for your time and attention to these important matters before you.

REPORT ON THE SYSTEM OF CRISIS CARE FOR PEOPLE IN RECOVERY

A Project of the North Central Regional Mental Health Board

Site Visits Conducted July 2014 – 2015

Respectfully Submitted:

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Final Report – August 2015

EXECUTIVE SUMMARY

Report on the System of Crisis Care for People in Recovery

North Central Regional Mental Health Board
August 2015

Members of North Central Regional Mental Health Board wish to thank its six Catchment Area Councils (CACs), the Local Mental Health Authorities (LMHAs) in Region IV, agencies providing mobile crisis services, their staff, and persons in recovery who participated in the discussions held during this review. We hope that all the participants see this report as their opportunity to convey to the Department of Mental Health and Addiction Services their perceptions and recommendations.

In FY 2014-15, the North Central Regional Mental Health Board (NCRMHB) conducted a review of DMHAS funded mobile crisis programs and community supports in Region IV to achieve the following objectives:

1. Understand the particular crisis care models and outpatient crisis management currently available in the region
2. Document how mobile crisis care has been implemented; and
3. Assess the effectiveness of crisis care programs in creating recovery pathways for people in crisis.

To do this work, NCRMHB conducted a series of reviews with agencies in Region IV that offer **mobile crisis support** programs. Additional site visits were scheduled with Town Social Services staff, police departments, families, clinicians, mental health professionals, and people in recovery. Finally, NCRMHB facilitated Catchment Area Council (CAC) discussions in order to gain a full picture of how crisis care programs impact people in Region IV. We looked at the role they play in helping people in crisis recover from triggered situations.

This report focuses on issues that arose from crisis program visits and interviews with persons in recovery, families, and key stakeholders as indicated above in each of the CACs in our region throughout FY 2014-15:

A total of **14 NCRMHB volunteers participated in the reviews as interviewers**. Review teams were comprised of NCRMHB staff, NCRMHB Review and Evaluation Committee members, and CAC members that included persons in recovery, family members, provider members, and concerned citizens.

We hope that our review efforts will stimulate further discussion among the region's mobile crisis programs, the agencies that provide inpatient and outpatient services, DMHAS, and our various community partners, so that system-wide and cross sector improvements can be made to broaden the impact and increase the effectiveness of crisis response and care in our region.

OVERVIEW

In Region IV, mobile crisis services are available under DMHAS contract to offer mobile, readily accessible, rapid response, short term services for adults (18 and over) experiencing episodes of acute behavioral health crises.

Mobile crisis services focus on evaluation and stabilization activities. These include assessment and evaluation, diagnosis, hospital pre-screening, medication evaluation and prescribing, targeted interventions and arrangement for further care and assistance as required. Mobile crisis services should be provided in person following a telephone screening when an individual is experiencing sudden, incapacitating emotional distress or other symptoms. **Mobile emergency crisis clinicians shall assist and collaborate with local police officers** to de-escalate and divert crises.

Mobile crisis services are evaluated by DMHAS on 5 measures. They are as follows:

1) Contractor will meet reporting requirements no later than the 15th day of each month.
2) Contractor will meet at least 90% utilization rate.
3) At least 75% of individuals requiring a face-to-face evaluation will be evaluated within 1.5 hours of initial request.
4) At least 80% of all mobile crisis evaluations will be conducted in the community (person's own community settings - outside of clinical care, within neighborhoods, people's residences, schools, parks, etc.).
5) At least 90% of individuals evaluated by mobile crisis will have at least one other service within 48 hours.

However, it should be noted that mobile crisis services are not evaluated on measures involving people's experiences, nor on diversion from emergency room, from hospitalization, or from incarceration. These are measures that can indicate success but that are not currently considered.

REGION IV MOBILE EMERGENCY CRISIS SERVICES LOCATIONS

CAC 15 & 17:
Community Health Resources (CHR) – Enfield & Manchester Crisis Services
995 Day Hill Rd., Windsor, CT 06095

CAC 16:
InterCommunity (IC) – Crisis Services
281 Main St., East Hartford, CT 06118

CAC 18 & 23
Capital Region Mental Health Center (CRMHC) – Mobile Crisis
500 Vine St., Hartford, CT 06112

CAC 19:
Wheeler Community Response Team (CRT) – CMHA
91 Northwest Dr., Plainville, CT 06062

- **Community Health Resources (CHR)** has **2** staff plus the mobile crisis director weekdays from **9am-9pm**, and weekends **10am-8pm**. All calls go through the CHR Assessment Center. After-hours calls roll over to the Institute of Living (IOL). The IOL Assessment Center pages the MCRT on-call clinician after hours to manage CAC 15 and CAC 17 area crises. The MCRT on-call clinician determines how to manage the crisis and develops a crisis plan: if in an imminent crisis, the IOL Assessment Center and/or MCRT on-call MCRT Clinician will contact the appropriate police department for intervention; other dispositions include telephone contact with the consumer/family/provider to provide support and to arrange a crisis assessment the next morning. CHR is a provider for **Emergency Mobile Psychiatric Services (EMPS)** for children and adolescents who are experiencing psychiatric or behavioral health crises.

- **InterCommunity (IC)** mobile crisis unit has **3** full time LCSW clinicians, and **1** non-licensed therapist. In addition, 3 other staff are on-call to respond to after hour emergencies. Calls roll over to IOL at **4:30pm**, and mobile crisis is available until **11pm.** There has been a reduction of mobile crisis calls from previous years partly due to the availability of walk-in same day access. IC has EMPS for a six town catchment area: East Hartford, Wethersfield, Marlborough, Rocky Hill, Newington and Wethersfield. IC's Addiction Services division (formerly ADRC) has a detoxification center and the SATEP access line number is contracted through Advanced Behavioral Health.

- **Capital Region Mental Health Center (CRMHC)** offers mobile crisis and intake services from the same unit. The intake team is staffed by 2 people with availability of psychiatrists and APRNs. Daytime mobile teams have **5** people, and evening teams have **3** people covering a shift from **4pm - 12:30am**. Generally, 3-4 mobile crisis visits occur per day. All mobile crisis staff are Crisis Intervention Team (CIT) trained.

- **Wheeler Community Response Team (CRT)** provides mobile crisis services under contract with CMHA. Wheeler operates 2 shifts with a part-time therapist and **2** clinicians each offering face-to-face service **until 10pm**. Outreach is done in pairs. On weekends, the office operates **9am-5pm** with non-licensed staff. There is telephone support 24/7, and 3 shifts with a licensed clinician on call. Wheeler also provides **2-1-1** back up for the whole state. Mobile crisis staff may provide short-term case management as a bridge service if there is a waiting list for case management through CMHA. Wheeler is a provider for national suicide hotline and is also a provider for **EMPS**. Wheeler also offers Helpline, which includes an Access Line for entrance to detox.

RELATED CRISIS CARE PROGRAMS

The state of Connecticut (CT) has made a significant investment in specialized training in the **Crisis Intervention Team (CIT)** model to respond to the needs of adults with emerging mental health and substance use disorders. The goal of the CIT model, described as a best-practice model by the Police Executive Research Forum, is safety: for the community, the law enforcement officer, and the person in crisis. Not only does the program promote safety for all involved, it also links the person in crisis to services in the community whenever possible. CIT is specially designed for the patrol officer – the first responder. The training is one forty-hour week, and involves safe de-escalation techniques, suicide risk assessment and prevention, mental

health and trauma, and real life individual and family perspectives on living with mental illness. After the one-week training officers receive periodic updates and annual advanced training. The training is fully funded by DMHAS and comes at no charge to federal state or local public safety agencies in CT. As the Director of the Memphis Police Department states, "CIT promotes education, sensitivity, understanding and the building of community partnerships."[1] As of August 2013, over 1700 police officers in 88 state, federal and local public safety agencies and their community mental health partners have received Crisis Intervention Team Training from the Connecticut Alliance to Benefit Law Enforcement (CABLE).[2]

In addition, **Specialized Crisis Intervention for Young Adults (SCYA)** is a unique partnership between DMHAS, Advanced Behavioral Health (ABH), CABLE, and the National Alliance for Mental Illness (NAMI). SCYA is being evaluated by researchers from UConn to track its impact on reducing treatment barriers and diverting young adults from the criminal justice system. The goals of SCYA include 1) engaging and linking young adults to treatment and support services, 2) providing training and ongoing consultation to CITs on engaging young adults in treatment or support services, 3) recognizing early psychosis, 4) identifying a statewide network of treatment providers and other resources for young adults, and 5) implementing young adult peer support groups statewide and networking through social media.

Finally, several new **Community Care Teams (CCT)** have been initiated in the Greater Hartford area following a model piloted by Middlesex Hospital. Currently, St. Francis and Hartford Hospital have a combined team, and Bristol Hospital has a team. There is one developing in Manchester. The Community Care Team model was developed to provide patient centered care and improve outcomes by developing wrap around services through multi-agency partnership and care planning. These teams are usually comprised of local community providers and agencies that deliver services. Medicaid Members who have complex, high risk factors and have been identified as "frequent Visitors" of the Emergency Department and Inpatient services are typically the targeted cohort. The desired outcome is that the pattern of ED utilization and other higher level of care services will be interrupted by the customized care efforts of the local CCT. These teams can also be instrumental in creating innovative interventions that result in expediting referral response time, promoting connect to care initiatives, exploring housing alternatives and decreasing readmission rates for inpatient levels of care. Value Options is supporting 5 Community Care Teams in CT. Each team has been assigned one Value Options Intensive Case Manager (ICM) and 1 Peer Specialist (Peer), who work with identified individuals to assist with connections to care and wraparound services.[3]

R&E MEMBERS' QUESTIONS

During our crisis care review, our R&E members asked, "Do we have a good system of care that needs to be tweaked, or do we have the wrong system?" The R&E team wondered, "What gaps exist and what collaboration is needed among all the key players in a crisis to de-escalate or to

[1] CABLE website, 2013 Connecticut Alliance To Benefit Law Enforcement

[2] NAMI Connecticut and CABLE informational flier

[3] Dan Langless, ValueOptions Regional Network Manager - Letter to the Community, Connecticut BHP, September 2014.

prevent future crises?" Another question that frequently arose was, "Is it a matter of geography?" Why does the crisis care system work better in some towns than others? Is people's quality of care dependent on where they live? The variables of geography and resources of different CACs may contribute to an uneven system of care.

Overall, the R&E team concluded that a large number of police and emergency responders still **need CIT training**, that hospital care and discharge are problematic, and there is widespread fragmentation and gaps within the continuum of care in the mental health system. People considered it unfortunate that the "CIT training is a voluntary program and many first responders lack the awareness and skills necessary to deal with mental health crises." The team believed that "Crisis is a make-or-break moment when these skills and understanding are of utmost importance." However, people agreed that other parts of the response system need to be shored up as well in order to resolve crises.

A **current challenge** facing crisis care is the **waitlist**. According to some service providers, even if the agency offers same-day access, people in crisis still cannot see a psychiatrist right away. If **access to psychiatric services is not available promptly, crises are likely to persist** and even escalate. A mobile crisis director shared that approximately 40-50% of clients seen in Region IV are unknown to the evaluating crisis team. This means more people are having crises and people do not have enough access to care. Moreover, calls directly from individuals (rather than from clinicians or mental health or addiction centers) have increased – which poses particular challenges when mobile crisis staff are unable to refer to people's previous history. Staff must grapple with whether behaviors or symptoms are attributable to substance use rather than mental health, whether the individual has a history of violence, or homicidal or suicidal ideation.

Some new options are available to alleviate crisis thanks to the passage of recent legislation. For example, the **increased availability and use of Narcan,** an opioid overdose reversal drug, helps avert drug-induced crisis. According to the Hartford Dispensary, Narcan can be prescribed to family members, agencies can buy Narcan for community health workers, and police and other emergency responders can carry and dispense Narcan in emergencies they encounter. Legislation was recently passed to allow a pharmacist to provide Narcan following provision of a brief educational session but this is rolling out in October 2015; it has not started yet. Narcan will also be able to be dispensed directly by trained and certified pharmacists without a physician's order. The inhaler application is easy to use and as inexpensive as the injectable form. Additionally, the price of Narcan has gone down, making it more accessible to more people.

OVERALL STRENGTHS

Region IV's mobile crisis teams are strong in these key ways:

1) **Low Staff Turnover**: Most crisis teams have low staff turnover, which means staff know and understand individuals in crisis as well as the communities they live in. This leads to more effective and efficient responses to crisis situations.

2) **Strong Integration within the Local Mental Health Authorities (LMHAs)**: Mobile crisis teams work well within their LMHAs. They go to debrief meetings, share pertinent information daily, and actively work with clinicians and mental health agency staff as part of a team to address crisis issues. Mobile crisis teams are a valued part of LMHAs. With the exception of CMHA, who outsources to Wheeler, Region IV's LMHAs have integrated mobile crisis units. Even with CMHA, Wheeler's mobile crisis staff are improving at communications and meet weekly with CMHA about people at highest risk.

3) Social services staff report that **mental health crisis responders are very good at assessing a situation quickly** and taking charge of an often chaotic environment. Crisis responders in general are well informed on the community resources, wait lists and referral procedures that often expedite treatment and keep insurance costs down by avoiding a hospital visit if unnecessary.

4) Mental health crisis responders do a good job of **providing crisis debriefing, psychological first aid, post-traumatic stress management and providing resources**. They will do whatever is needed and are community involved. They do need more and improved training especially for universal screenings and suicide prevention.

5) LMHAs that operate **Enhanced Care Clinics (ECC)** offer an important treatment resource for people in crisis**.** These clinics have a higher Medicaid rate and they must provide certain services in a critical timeframe to respond to crisis care needs. ECCs in LMHAS make it easier for ERs to discharge people into community. Wheeler, CHR and InterCommunity operate ECCs.

6) The **longevity of Crisis Team staff** in all locations speaks to the strength and knowledgeable nature of these mobile crisis teams. They are truly an asset to crisis care.

OVERALL RECOMMENDATIONS

Recommendation #1: Increase Collaboration and Communication between Region IV Crisis Care Professionals (mobile crisis, emergency and inpatient psychiatric settings, town social services, police, shelter programs, etc.)

Effectively triaging and connecting people in crisis to appropriate services is greatly enhanced when a strong collaborative relationship exists between mobile crisis, hospital staff, town social services, police, and shelter programs. Our review team observed that mobile crisis teams that regularly met with police, town social services, and homeless shelter directors were able to establish relationships and **create a network of support for people in crisis, thus reducing churn** and aiding with recovery efforts. This is especially important for towns at the edges of the catchment area. Because these towns are at the periphery and may have smaller segments of the population, they may be harder to reach in time and as a result, may rely more on good police response. Mobile crisis staff from various catchment areas can also meet to learn from one

another. Identifying best practices among and between towns in our region will only strengthen their work.

Another barrier to good patient care during crisis is the **reach of coordination** on the part of discharge planners on inpatient units. High-risk people stabilize to the point of discharge to the community, but community providers aren't included in discharge plans and sometimes aren't notified of the discharge before it happens, even though providers make attempts to communicate with inpatient staff. Part of this stems from the confusion around HIPAA laws. CMHA has a written contract that meets HIPAA standards, but the police are not invited to crisis meetings due to HIPAA restrictions. In contrast, CHR's interpretation of HIPAA is that it is **okay to share information in an emergency,** so there can be information sharing with police and other first responders. CHR staff believe that **under continuity of care, responders can share information in compliance with HIPAA**. CHR's interpretation of HIPAA enables sharing information with the police and other clinicians and community supports, as needed. Regardless of whose interpretation is more accurate, there needs to be clarification around HIPAA and how to make information less restricted to help people in crisis.

Improvement is needed in the areas of communication and collaboration with community providers and stakeholders. Often when mental health providers make referrals such as to DCF, DSS, or APS, no follow up takes place. This leaves the referral source with questions regarding responsibility about follow up. **Improved communication and collaboration is needed** for continuity of care. The transition from hospital to community needs to be a group effort. Communication regarding the discharge plan needs to be communicated to the providers who will be resuming or beginning treatment as well as to a social worker/case manager to ensure that discharge planning, referrals, and paperwork were completed. One therapist said it is important to have an open dialogue – where everyone involved in a person's life is invited to the table to talk about different perspectives and plan for averting crises together.

Recommendation #2: Focus on Training Police

Many issues arise from lack of understanding and knowledge about how to approach people in crisis from mental health or addiction issues. Numerous personal accounts and studies confirm that police with CIT or Mental Health First Aid training more successfully avert and/or respond to crises than their untrained counterparts. Additionally, it is important to expand training to EMTs. Also, communication is very important between mental health providers and local police.

Recommendation #3: Develop alternatives to hospital psychiatric settings for people experiencing mental health crises.

Develop alternatives along the continuum of care for people who are able to step down from inpatient care but need higher levels of support for safe discharge back into the community. Some useful programs that could be expanded include: respite, more step down beds, more ACT teams, detox and substance abuse treatment for people who are actively using but not yet in crisis, visiting nurses for disabled or older adults, more options for structured programming during the day, meaningful substance use treatment for young adults, assisted living for people

with co-morbid conditions, dementia, diminished cognition, or medical complications from the psychiatric medications they are taking,

Access to care for people who need more structure and support is lacking for youth and adults. If a person needs help filling out forms, applications or paying bills, and has no family or other support, they will lack consistent care and may end up homeless or worse. The consequence of not accessing appropriate levels of care is crisis. It is frustrating to see people get into chronic life situations when it could be prevented.

One therapist said there should be more variety and homey relationship-based crisis centers with respite programs. "There should be opportunities for learning and lifestyle changes, instruction on nutrition, yoga, and a clinical team comprised of peers, a shelter without expectations. There should be a **variety of places of care to choose from**: EDs, inpatient care with medication management and crowd control, and peer respite programs."

Access to care for people who need more structure and support is limited. **More group homes** are needed. The barriers to each point in the continuum of care could be ameliorated with a coach to help individuals find and apply for resources. The consequences of not accessing appropriate levels of care are 1) readmission to the hospital, 2) not being able to integrate back into the community, and 3) frustration, challenges for people, and feeling like they are alone and on their own.

More resources are needed for existing services to **provide longer periods of service**. This insures that people are stabilized before release into the community, and that once there, they have the supports needed to maintain stability. Another frustration is that mobile crisis staff and clinicians cannot place someone into Intermediate Care beds if they are homeless; the person must have an identified place to go to as part of their disposition. To create proper transitions from hospital to community, **more structured community support services** are needed.

Recommendation #4: Monitor and Improve 2-1-1 and the Coordinated Access System for Housing or Shelter Referrals

Many people commented about difficulties experienced with the transition to the new Coordinated Access System for housing or shelter referrals (all referrals and appointments for priority designation must now go through 2-1-1). Since 2-1-1 is now a clearinghouse for shelters, the service is inundated with calls and the wait time is problematic. Return calls from the service are also unreliable. Phone wait times are a particular challenge to individuals who are homeless and without a cell phone or on a cell phone with limited minutes. Referral for housing is now a two-step process, with the second step being the assessment for priority designation (using the Vulnerability Index – Services Prioritization Decision Assistance Tool, or the VI SPDAT) Wait times, although improving, are also problematic for this step. There is a lot of work to be done to make 2-1-1 and the Coordinated Access Network a dependable referral system for people who are homeless.

Recommendation #5: Education at the Community Level

Educate the broader public on mental health and addiction issues. Educate employers. Create a community where people in recovery can be welcomed to live and work via advocacy and education efforts.

There is a misunderstanding about what EDs can reasonably do for people. People are disappointed to find that insurance does not fund detox. There should be an emphasis on community-based treatment – hospitalization should not be the first course of action; we must ensure that all other least restrictive settings have been considered. There also should be education of families and community referrals on the role of mobile crisis, assessment versus hospitalization, and the use of Emergency Certificates (EC), in which an M.D. must assess someone within 24 hours.

A woman from another part of the state shared that she was arrested during crisis. The friend who called mobile crisis for the woman was concerned for her well-being. They called 2-1-1 and could not connect even though it was at the middle of the day on a Friday. They had to call 9-1-1 so police came, but she was seeking psychiatric help. Police involvement was a result of a breakdown in communication. She said that mobile crisis responders eventually came but by this time she was deep in crisis and she did not feel heard. Her situation was not treated appropriately, there was no follow-up, and she tried to articulate that she needed help as things were spiraling, but she was arrested instead of treated. Her friend noted that people outside of the mental health system do not have the language to discuss their situation. This lack of understanding stems from the **need for more education at the community level**. The woman in crisis would have benefited from knowing what to say or how to behave in these trying circumstances, and police would have benefited from knowing how to better de-escalate the situation.

Recommendation #6: Review DMHAS Quality Standards and Measures Tracked for Monitoring Performance

While we are trying to improve mobile crisis programs, it is important to be clear about quality standards for DMHAS and measures used for tracking performance on the DMHAS Provider Quality Report. One of the quality standards requires providers to provide assessments "in community locations" 80% of the time. However, there are varying interpretations of "community locations" among providers. IC included their clinic setting as a "community" location, but CHR and CRMHC staff feel strongly that crisis assessment should be conducted in the person's home environment or natural setting where crisis is occurring. Due to their differing interpretations of "community settings" – IC got a higher score on the "community" measure than CHR and CRMHC on the DMHAS Provider Quality report. Due to these differing interpretations, it is difficult to measure adherence to the "community" standard. Additionally, the 48-hour measure is problematic because the client must touch another DMHAS organization in the 48 hours to count as a follow up. This measure doesn't gauge all follow up, it only acknowledges DMHAS touches as follow up. It does not even include mobile crisis follow-up. The 48-hour measure therefore does not accurately assess follow up outside of DMHAS. And very importantly, there are no standards or measures that reflect outcomes for the person in crisis - the quality of the individuals' experience or diversion from hospital or incarceration.

Recommendation #7: Promote the Use of Community Care Teams, Gridlock Committee and Central Access Networks

One person from CAC 23 noted, "ERs are Band-Aids that treat symptoms and then let them go." To address complex medical conditions, people need teams of clinicians and healthcare providers to help them manage their health. We need to promote these essential services as a means of enhancing care, improving discharge planning and follow-up, and ameliorating outcomes for people for whom crisis response results in emergency or inpatient hospitalization. Community Care Teams can help address the need for a warm hand-off and work with ERs on releasing people before they are stabilized. Community Care Teams (CCT), the Gridlock Committee, and Central Access Networks (CAN) all serve to address complex cases, to resolve gridlock issues in hospitals, and coordinate to better triage people in crisis.

The Camden Coalition (CC) in New Jersey is an example of how we can continue to address complex medical cases and help the high utilizers of EDs and hospitals. Camden Coalition members share information through the **Camden Health Information Exchange** (Camden HIE). With relevant, real-time data, CC's cross-disciplinary **care teams** connect quickly with people who have high rates of hospitalization and emergency room use, and help them address their complex needs. Since 2002, CC has been demonstrating that human-centered, coordinated care, combined with the smart use of data, can improve patients' quality of care and reduce expensive, ineffective inpatient stays and emergency room visits. The Coalition holds a **monthly Care Management Committee meetin**g that rotates between the hospitals and is attended by social workers and other supportive services providers from across the city. This committee helped to oversee the development of the high utilizer team and continues to advise the Care Management Program.

Through the Coalition's work with high utilizers the staff has built close relationships with emergency room physicians, hospitalists, specialists, social workers, and nurse discharge planners across the city. These relationships are crucial to the team's success and ensure good discharge planning and care coordination upon discharge.

Recommendation #8: Develop Cultural Competency

Diversity of staff should be improved in mobile crisis care. Increased clinical trainings and better relationships with diverse communities also helps. Clinicians need more time and training devoted to multicultural issues. Clinicians-in-training need a field placement requirement for at least one semester so they can see exactly what's going on. According to hospital staff, "language lines" don't work well. Additionally, they admit "we have a difficult time working with deaf patients. Sign language interpreters are expensive (must reserve for a minimum of two hours). And you have to call ahead so it doesn't work for crisis!" Clinicians must learn to work with people across cultural and language barriers.

Mental health services are geared towards Caucasians. In many minority cultures, it is not acceptable to talk about mental health issues. The shame and stigma around mental health and addiction can exacerbate issues. At Asian Family Services – Asians are able to accept help for mental health issues because the organization takes the time to talk about physical ailments and build up trust and relationships. However, mainstream health providers do not make the time nor allocate resources for this. Sometimes sessions for minorities may take longer because they need time to gain trust. Our

system must do a better job at understanding culture. It is also important to help gear people towards a positive, change-maker role. Clinicians need to do a better job of listening actively and reading non-verbal cues.

Recommendation #9: Increase Number of Staff Working in the Mobile Crisis Units.

Every LMHA lauded the work of mobile crisis units. LMHA staff often stated that issues could be averted or improved if they called mobile crisis sooner and more often. However, at least four of our catchment areas talked about concern over the small number of staff working in the mobile crisis units. Many people wondered whether that is sufficient to meet the need.

CONCLUSION

This report aims to provide an opportunity for a rich **exchange of ideas** among all the people in crisis care management, from mobile crisis and town social services to police, clinicians, case managers, families, and people struggling to maintain stability. Throughout the review and evaluation process, all the mobile crisis programs provided evidence of **thoughtful crisis management efforts, continuing efforts to improve practices, and a committed dedication to support recovery.**

Methods of Collecting Information:
The review teams surveyed police, town social services folks, family and individuals, clinicians, hospital staff who provide crisis care, staff from DMHAS-funded community health centers, and mobile crisis teams. They also attended NAMI meetings, interagency meetings, and attended CAC meetings. The notes drawn from these interviews inform the analysis of mobile crisis for the sections that follow and help us highlight some best practices.

The report is organized by Catchment Area Councils (CACs) and then subdivided into categories including mobile crisis programs, staff from DMHAS-funded community health centers, and issues raised by CACs. In the Appendix are interviews with police, town social services, families and individuals in recovery, and clinicians. Also included in the Appendix are innovative programs and questionnaires used by the committee.